

FAMILY AND MEDICAL LEAVE APPLICATION

Complete both pages of this FMLA application and forward within your department for appropriate acknowledgement and signature. Include a completed Leave of Absence form for leave requested beyond the 12 weeks of FMLA. If qualified, FMLA approved time-off is limited to 12 weeks within a 12 month period. Forward both forms together to Human Resources. (City Hall, 2nd Floor - Council Wing). Please keep copies for your reference.

Employee Name:	Work phone # :	Department:
Employee ID #:	Timekeeper Name:	T.K. Phone #

Section I: To be completed by Timekeeper:

Leave balances as of the end of pay period #: _____

Earned Hours Currently Available:	Hours Used in the Last 12 Months:
Sick Leave _____	FMLA Leave _____
Vacation _____	Disability Leave _____ (Workers' Comp)
Personal or Executive leave _____	

Timekeeper Signature

Date

Section II: To be completed by Employee:

I wish to use Family and Medical Leave from (exact dates): _____ through (and including): _____ for the following purpose:

- | | |
|---|--|
| 1. <input type="checkbox"/> Birth of child, due: _____ | 4. <input type="checkbox"/> My own serious medical condition |
| 2. <input type="checkbox"/> Adoption of child, arriving: _____ | 5. Seriously ill: <input type="checkbox"/> child under 18, <input type="checkbox"/> spouse, <input type="checkbox"/> parent. |
| 3. <input type="checkbox"/> Placement of a foster child, beginning: _____ | 6. <input type="checkbox"/> Seriously ill child over 18 with special circumstances |

I have already used _____

hours of paid or unpaid leave for this FMLA purpose

In the past 12 months I have also taken _____

hours of designated and approved Family and Medical Leave

I intend to use _____

hours of paid leave (the balance of my personal or executive leave, and the maximum sick leave available to me for this FMLA purpose)

I wish to use _____

hours of unpaid Family and Medical leave.

FMLA SUBTOTAL _____

Must not exceed 480 hours, or my regularly scheduled hours for 12 weeks

And I wish to use _____

hours of additional unpaid leave, as reflected on the included Request for Leave of Absence form, beyond the total eligible hours for Family and Medical Leave.

Medical Verification (Certification of Health Care Provider) is required. An additional form is available for this purpose.

- ✓ Your doctor must submit medical verification directly to: HUMAN RESOURCES; RETURN TO WORK COORDINATOR (Mail: Return to Work Coordinator, City of San Jose, 200 E. Santa Clara Street, San Jose, CA 95113; Fax: 408-292-6447). Verification must state the date serious medical condition commenced and its probable duration. If you are requesting leave to care for a family member, that person's health care provider must state the date that a serious medical condition commenced, probable duration and that your care is required—and you must sign a statement stating what care you will provide. You must also submit a schedule if your leave is to be taken intermittently or if it will be necessary for you to work less than your regular full schedule.
- ✓ Medical verification should NOT be attached to this form. Copies must not be retained in department personnel files. Your Department Head may contact the Return to Work Coordinator to verify that the information provided in your medical verification is appropriate for Family and Medical Leave.

Employee Certification is required

I understand that if I qualify and have not already taken 12 weeks of leave for a family and medical leave purpose in the last 12 months, I am eligible for continuation of the **City paid portion** of my medical, dental, vision and employee assistance program (EAP) insurance during my unpaid Family and Medical Leave (for the balance of the 12 week period available under the Family and Medical Leave Program) provided that I supply the required medical verification and that I pay my portion of the cost of my medical, dental, and vision insurance during this unpaid leave.

I understand that I must return to City service for at least 30 calendar days after the end of my Family and Medical Leave. If I do not, I may be required to repay the City of San Jose for any City-paid medical, dental, vision, and EAP insurance contributions made on my behalf during the unpaid portion of my leave. During my leave I will notify the City of any change in my address.

Employee Signature

Home Address

Date

Section III: To be completed by Department Head or designated Deputy: ☐ I acknowledge receipt of this request for Family and Medical Leave.

Department Head Signature

Print Name

Date

AUTHORIZATION TO RECORD PAID AND UNPAID TIME DURING FMLA LEAVE

For 1st 12 weeks of leave if FMLA eligible

For additional information or assistance to complete this form, please see your Department Timekeeper.

I understand that:

- ❖ Paid time-off may not exceed my currently available leave balances. I won't have to use time that will accrue while on paid leave.
- ❖ The following authorized use of time may not be changed by time submitted on a timesheet during my leave unless a revised Authorization to Record Paid and Unpaid Time is submitted prior to the pay period during which a change occurs. If I submit paid time which differs from this Authorization, it is understood that this additional paid time will not be paid.
- ❖ I am responsible for arranging in advance to pay the cost of benefit premiums to continue my benefit coverage during the unpaid portion of my leave. I must pay the total cost (employee and City contributions) to continue health, dental, vision, and employee assistance program coverage unless I am entitled to leave under the Family and Medical Leave Act of 1993. If I am currently enrolled in the LTD insurance plan, my eligibility for LTD insurance will cease after the initial 60 days of leave, unless I have an active claim during this time. If I chose to pay Life Insurance premiums while on leave, eligibility for coverage will cease after 18 months. The Family and Medical Leave Act of 1993 provides for a total of up to 12 weeks of payment by the City of San Jose of the City's contribution to the cost of my health, dental, vision and employee assistance program insurance per year while using Family and Medical Leave.

My first day of absence from work for this leave will be: _____

My first day of paid leave from work will be: _____

My first day of unpaid leave from work will be: _____

I am regularly scheduled to work: _____ hours per week

I am regularly scheduled to work the following S=___ M=___ T=___ W=___ Th=___ F=___ S=___

hours, per day, each pay period: S=___ M=___ T=___ W=___ Th=___ F=___ S=___

I expect to return to work on: _____

Pay Period # _____ from ____/____/____ through ____/____/____ _____ hours regular work or holiday _____ hours sick leave PER or EXE leave hours: _____ _____ hours vacation _____ hours compensatory time off _____ hours paid disability leave (Worker's Comp) _____ hours of unpaid time, if paid leave exhausted	Pay Period # _____ from ____/____/____ through ____/____/____ _____ hours regular work or holiday _____ hours sick leave PER or EXE leave hours: _____ _____ hours vacation _____ hours compensatory time off _____ hours paid disability leave (Worker's Comp) _____ hours of unpaid time, if paid leave exhausted		
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Employee Signature: _____	Last name: _____	First name: _____	Date: ____/____/____